Brushing Up on Children's Oral Health in Louisiana

A Policy Brief

A project of Agenda for Children and the Oral Health Program, Office of Public Health, Department of Health and Hospitals

Sponsored by the Department of Social Services - Office of Family Support State Head Start Collaboration Project and Maternal and Child Health Program, Office of Public Health, Department of Health and Hospitals

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This policy brief was produced through the work of the Louisiana Children's Oral Health Initiative, a coalition of advocates who believe that all of Louisiana's children and families should have access to necessary oral health services. The purpose of the Louisiana Children's Oral Health Initiative is to eliminate the barriers that Louisiana's children and families face when they are trying to access oral health services.

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Agenda for Children

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The Louisiana Dental Hygienist's Association

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The Tooth Bus

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Executive Summary

Children's oral health is an epidemic. Dental care is the most prevalent unmet health need of children in the United States [1] Tooth decay is the most common chronic disease of childhood. It occurs five times more frequently than asthma and seven times more frequently than hay fever. [2] It is a tragedy that children's suffering, as a result of untreated oral disease, is almost entirely preventable.

In Louisiana, children 's oral health is in a state of crisis. Only 37% of Medicaid -eligible children received dental services during the last year. It is not until age 7 that 90% of children visit a dentist.[3] Children that are suffering from dental pain cannot focus or concentrate. They have difficulty attending to tasks, and experience high levels of anxiety, irritability and depression. When oral health is neglected in adolescence, problems continue into adulthood. Chronically poor oral health has been associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunction in adulthood.[4]

This oral health policy brief documents the barriers that children and families face when trying to access oral health services. We believe that by addressing the following problem areas, outcomes will dramatically improve for children in Louisiana.

1. **Focus Area**: **Prevention** Louisiana is not taking full advantage of the proven preventive measures available to prevent oral diseases. Community water fluoridation, the single most effective and efficient means of preventing tooth decay, is currently available to 48% of Louisiana communities. Dental sealants are very effective in preventing dental decay on the chewing surfaces of molar teeth. In 1998 only 22% of surveyed Louisiana 3rd graders had dental sealants, which is well below the Healthy People 2010 objective of 50% (Healthy People 2010 is a national initiative of the U.S. Department of Health and Human Services.)
2. **Focus Area: Low Provider Participation in Medicaid/LaChip** Medicaid eligible children in Louisiana are 3-5 times more likely to have untreated dental decay than non eligible children. Though there are several factors that contribute to low utilization rates of dental services among low- income Medicaid -eligible families, the most prevalent is finding a dentist to treat them.[5] In some areas of the state, the waiting list to see a dentist that accepts Medicaid is 4-6 months. The reasons

that dentists cite for non-participation include low reimbursement rates, broken appointments, and administrative burden.

3. **Focus Area: Availability of Dentists** There is an inequitable distribution of dentists through out the state, especially in rural areas. Sixteen Louisiana parishes are designated by the federal government to be Health Professional Shortage Areas. (HPSA) There is a crucial shortage of pediatric dentists in the nation, and in Louisiana only 15 pediatric dentists are accepting an appreciable number of Medicaid patients. Most school based health centers, an ideal setting to address children's health needs, do not have a dentist accepting referrals for the children in need of dental services.
4. **Focus Area: Community Education** Fear and misunderstanding about oral health must be eliminated. The benefits of preventive oral health cannot be effectively implemented without public understanding and support. The lack of adequate education can have devastating effects on pre-term low birth weight infants and early childhood dental caries.
5. **Focus Area: Children with Special Health Care Needs** One in four parents of a child with special health care needs claim their child is in need of dental care. Twenty- nine percent of children in Louisiana have some form of disability.[6] The Americans with Disabilities Act requires that dentists treat patients with disabilities on the same basis as they treat patients without disabilities. Often dental students and dentists are inadequately prepared to treat patients with disabilities who often exhibit more severe forms of dental problems, have complicated medical histories, and can require special accommodations and scheduling.

By addressing each of these focus areas, we can begin to eliminate the barriers that deny children full access to oral health care. Implementation of the recommendations and strategies outlined in this policy brief will begin to ease the burden on vulnerable children and families.

Policy Priorities

Louisiana Children's Oral Health Initiative

Focus Areas	Recommendations	Implementation
Prevention: • Community Water Fluoridation	• Increase the number of Louisiana residents that receive the benefits of community water fluoridation.	• Provide funding incentives for new community water fluoridation programs. • Increase the public's awareness of benefits of community water fluoridation.
• Dental Sealants	• Increase the number of children with sealants on their permanent molar teeth.	• Increase the number of school-based dental sealant programs. • Increase public awareness of the benefit of dental sealant application to prevent dental caries.
Low Provider Participation in Medicaid/LaCHIP: • Reimbursement Rates	• Raise Medicaid reimbursement rates to the 70th percentile of the current fee scale	• Enact legislation that raises Medicaid reimbursement rates to the 70th percentile of the current fee scale
	• Expand the Medicaid EPSDT dental periodicity schedule to include two exams and cleanings per year.	• Enact legislation that increases the Medicaid EPSDT dental periodicity schedule from one yearly exam and cleaning to two yearly exams and cleanings.
• Broken Appointments	• Educate families on importance of keeping dental appointments.	• Conduct a public awareness campaign that will educate parents on preventive care and the importance of regular dental visits.
• Administrative Burden	• Streamline the processing of claims and reimbursement.	• Support electronic claims processing statewide. • Explore options to support dentists financially for implementation of electronic claims processing.
• EPSDT Compliance	• Assess EPSDT compliance.	• EPSDT data collection should be revised to emphasize the number of children who receive all of their EPSDT screens in a timely fashion, with zero impact on the administrative responsibilities of dental providers.

Availability of Dentists: • Rural Louisiana	• Increase the ratio of dentists to residents in designated dental Health Professional Shortage Areas (HSPA) in Louisiana.	• Create a state supported loan repayment program that will provide financial incentives for dentists to work in rural areas in federally designated dental HPSAs.
	• Relieve families of financial burden of accessing transportation to dental appointments.	• Expand Medicaid to cover transportation for families in parishes that are federally designated dental HPSAs.
• Pediatric Dentists	• Increase the number of pediatric training positions at LSU School of Dentistry.	• Access available resources for residencies in pediatric dentistry. • Identify new funding opportunities for residencies in pediatric dentistry.
	• Train non-dental providers to provide referrals and oral health guidance/counseling to families with young children.	• Train pediatric nurses, medical students, and pediatricians, through medical schools and continuing education courses, to provide referrals, preventive oral hygiene practices, and fluoride supplements in non-fluoridated areas.
	• Utilize early childhood educators to promote oral health for children in daycare.	• Provide education and training on oral health to early childhood educators.
• Dental Auxiliary Workforce	• Increase the utilization of dental hygienists and expanded duty dental assistants in the community workforce setting in underserved areas of the state.	• Investigate options for expanding supervision for hygienists and expanded duty dental assistants in community settings in underserved areas of the state.
• School Based Health Centers	• Increase the proportion of school based health centers with an oral health component.	• Identify funding opportunities to increase the dental treatment component of school based health centers. • Identify dental providers in communities who will accept referrals from school based health centers without a dental component.

Community Education: • Public Awareness	• Increase public awareness of oral health through a statewide media campaign. • Implement comprehensive school health curricula with an oral health education and prevention component in all Louisiana schools.	• Develop a comprehensive statewide oral health education and awareness campaign. • Design a comprehensive oral health education curriculum for elementary and secondary school children. • Work with the Department of Education and state legislators to promote oral health as a mandated part of the school curriculum.
• Pre-term Births	• Provide dental coverage for Medicaid eligible pregnant women beyond the age of 21. • Provide pre-natal education to all pregnant women with an emphasis on the established relationship between poor maternal periodontal health and pre-term low birth weight babies.	• Enact legislation that provides dental coverage for Medicaid eligible pregnant women beyond the age of 21. • Target pre-natal women through the WIC program and other community health centers to provide oral health education.
• Baby Bottle Caries (tooth decay)	• Implement an oral health component developed specifically for the young child that can be utilized in all daycare settings.	• Provide training to childhood educators on preventive oral health practices.
Children with Special Health Care Needs	• Increase the number of dentists that are willing to treat children with special needs.	• Provide adequate training in the dental curriculum for treating mentally and physically challenged patients. • Provide clinical experiences in treating special needs patients for the dental students. • Provide continuing education and training to the practicing dentists in the community for treating special needs patients.

INTRODUCTION: CHILDREN'S ORAL HEALTH

"We find it unacceptable that, in 21st century America, we have children who cannot eat or sleep properly, can't pay attention in school, because they suffer from untreated dental disease. It is especially tragic because it almost entirely preventable." Dr. Chadwick, President of the American Dental Association, April 2002

"Since my first encounter with a child patient in 1970, I have been aware of the stark disconnect between perception and reality around children's oral health. The too-widespread belief that childhood dental disease has been vanquished stands in contrast to the thousands upon thousands of toothaches and acute abscesses experienced daily by America's children – many as young as two years of age." – Dr. Burton Edelstein, DDS, MPH, Founding Director of the Children's Dental Health Project.

"When it comes to oral health, America is like a student with straight "A" potential in danger of failure. The nation has made great progress over the decades in improving oral health. The nation's economy is moving at a record pace. Medical and scientific progress has opened a new understanding for oral health. Yet, serious gaps in prevention and access have halted progress and are putting the health status of the nation at risk." –Surgeon General David Satcher

No child can be truly healthy without good oral health. Though it may appear to be insignificant, children's oral health is a critical public health problem. Dental care is the most prevalent unmet health need of children in the United States.[7] Tooth decay is the most common chronic disease of childhood. It is five times more frequent than asthma and seven times more common than hay fever. Twenty-five percent of all children have untreated tooth decay in their permanent teeth.[8]

The improvement of oral health in the U.S. has been cited as one of the major public health successes of this past century. However, a "silent epidemic" of oral diseases is affecting our most vulnerable population – poor children.[9]

- Seventeen percent (17%) of preschool-aged children and 50% of school- aged children have experienced tooth decay in their primary teeth.[10]
- Sixty percent (60%) of adolescents have gum disease.[11]
- The average adolescent in America has 4 decayed, missing, or filled tooth surfaces.[12]
- Thirty-one percent (31%) of all children aged 6 through 8 and 22% of 15 year-olds have untreated dental caries.[13]
- Approximately 63% of children age 5 do not receive any oral health care each year.[14]
- By the age of 45, more than 99% of Americans have experienced tooth decay, which is largely preventable.[15]
- Someone dies from oral cancer every hour in the U.S.[16]

Louisiana received a "C-" from the Oral Health America Report Card in 2001.[17] A study by the Louisiana Oral Health Program, in which school nurses screened third grade children throughout the state, revealed that 38.1% of children had untreated caries.[18] The well being of children in our state depends on assuring the highest level of oral health attainable. Educational, environmental, social, health system and financial barriers that put our most vulnerable population at risk for oral disease must be overcome.[19]

Oral Health is an Integral Part of General Health

"Oral health cannot be considered separate from the rest of children's health and well-being, just as the mouth cannot be separate from the rest of the body. Like other aspects of children's health, oral health must be considered in the context of social, cultural and environmental factors. Oral diseases are common, and many of them can be prevented with early cost effective interventions. Despite the availability of such measure, and improvement in children's oral health in recent decades, many children still lack needed dental care more in fact, than lack medical care." – Surgeon General David Satcher, 2001.

Chronically poor oral health has been scientifically associated with failure-to-thrive in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunction in adulthood.[20] When oral health is neglected in adolescence, it often continues into adulthood, affecting speech, nutrition, economic productivity, quality of life and health care costs. [21] Recent research has pointed to possible associations between chronic oral infections and diabetes, heart and lung diseases, stroke, and low-birth weight, premature births.[22]

More than 90% of all systemic diseases have oral manifestations.[23] Unlike medical care, lack of dental care is seldom identified as life threatening and therefore perceived as less important.[24] There must be a change in perceptions regarding oral health and disease, allowing oral health to become a recognized component of general health.

Oral Health Disparities

"There are profound and consequential oral health disparities within the United States population." – Surgeon General David Satcher

Research has shown that dental caries, periodontal disease, oral cancer and other genetic or acquired oral disease or dysfunction adversely affects all people, regardless of their physical, social, psychological, cultural, or economic environment. However, children and families that have inadequate access to oral health services are disproportionately affected by oral health problems.[25] Access is often defined as "a term used to describe a broad set of concerns that center on the degree to which individuals and groups are able to obtain needed services from the health care system." [26] Eight and one half percent (8.5%) of the U.S. population wanted, but could not obtain dental care in 1998.[27] Barriers to accessing oral health services are experienced by many Louisiana families, particularly those of low-income, minority populations.

Poor children do not have equal access to dental care. Eighty percent (80%) of tooth decay occurs in only 25% of children.[28] The children that are most vulnerable to tooth decay are often low-income, minority children. Twenty-five percent (25%) of children living in poverty have not seen a dentist before entering kindergarten.[29] According to Burton Edelstein, "poor preschoolers in America are twice as likely to have tooth decay, have twice as many cavities when they do experience decay, have twice the pain experience, yet have only half the dental visits as their affluent peers.[30] Poverty has become a social risk for disease. Income disparity between those who receive services and those who do not continues to increase, and the gap continues to widen.[31]

Racial disparities in access to oral health care services are significant. Latino children are more likely than any other group of U.S. children to be uninsured. About 1.1 million poor Latino children are uninsured compared with 806,000 White, 703,000 Black, and 95,000 Asian children.[32] Latino children have a disproportionately higher prevalence of dental cavities. Only 60% of Mexican American children ages 12-17 had cavities treated or filled compared with 87% of white children.[33] The 1999 Behavioral Risk Factors Surveillance System (BRFSS) survey shows that the length of time since the last dental visit was greater than 2 years in 39.4% of Louisiana's residents surveyed. There was a racial disparity found with the percentage of 50% for black residents compared to 34% for white residents.[34]

Efforts to reduce disparities in oral health must build on the societal values of equity and respect for cultural diversity.[35]

Oral Health Affects School Performance and School Readiness

"We all have a duty to call attention to the science and seriousness of early childhood cognitive development." – First Lady Laura Bush)

Early tooth loss due to decay can result in failure to thrive, reduced self-esteem, and the development of permanent disabilities that affect children's ability to learn and grow. American children lose 52 million school days each year due to oral health related illness.[36] According to Rothstein (2001), children who take a test while they have a toothache are unlikely to score as well as children who are not distracted by pain.[37]

Poor oral health has been associated with the following obstacles to learning and growth:

- Factors associated with pain – anxiety, fatigue, irritability, depression, and withdrawal from normal activities
- Inability to focus and concentrate
- Poor social relationships
- Difficulty attending to tasks
- Problems with eating and speaking
- Poor school attendance

Children in Louisiana are faced with an educational crisis. According to the Annie E. Casey Foundation's 2002 Kids Count report, 12% of Louisiana teenagers between aged16-19 dropped out of high school, 43% of 4th graders scored bellow basic math level, and 52% of 8th graders scored below basic math level.[38] The 1990 census showed that 28% of Louisiana adults function at the lowest literacy level.[39]

One of the basic assumptions of comprehensive school health states that educational outcomes are related to health status.[40] By dedicating time, energy and resources to improving children's access to oral health, we can improve school achievement among Louisiana's children.

Oral Health Expenditures

The United States still spends an estimated $60 billion annually on dental services, which includes about 500 million visits to dental offices.[41] Ninety-six percent (96%) of total expenditures on dental services are privately funded, primarily through payments out-of-pocket. Public coverage for oral health has been shrinking, and only 4% of dental services were paid through public programs in 1998.[42] The proportion of Medicaid dental expenditures as a percentage of all Medicaid personal health care expenditures has continued to decline. [43]

Medicaid is the second largest item in most state budgets, after elementary and secondary education. Though children are 51.2% of the Medicaid enrollees, they only [44]account for 14.9% of the total expenditures.[45] Dental care for children in the U.S. accounts for 20-30% of child health expenditures while dental care for children on Medicaid accounts for only an average of 2.3% of Medicaid child health expenditures.[46]

Because of inadequate access to affordable oral health care services, many parents use the emergency rooms as the primary source for their children's dental care. A trip to the emergency room is the first "dental" visit for one in four children.[47] A visit to the emergency room for a dental problem averages $123 for children under six and $142 for children ages 6-18.[48] The cost for preventable hospitalizations for dental-related illnesses averages $7,338 per individual.[49] A Louisiana study found that the average cost of children who had received dental services in a hospital operating room was $1508 compared with $104 for children who had received care in a dental clinic. Reducing severe oral health problems through early intervention and prevention offers substantial cost savings for the state.

FOCUS AREA: PREVENTION

Community Water Fluoridation

Community water fluoridation is the single most effective and efficient means of preventing tooth decay over a lifetime. The Surgeon General has hailed community water fluoridation as one of the ten greatest public health measures of the 20th century.[50] Water fluoridation is simply the addition of fluoride to the water to bring it to an acceptable concentration level that prevents the formation of dental caries. This acceptable level is one part fluoride per million parts of water. Fluoride added to the water supply is colorless, tasteless, harmless and odorless.

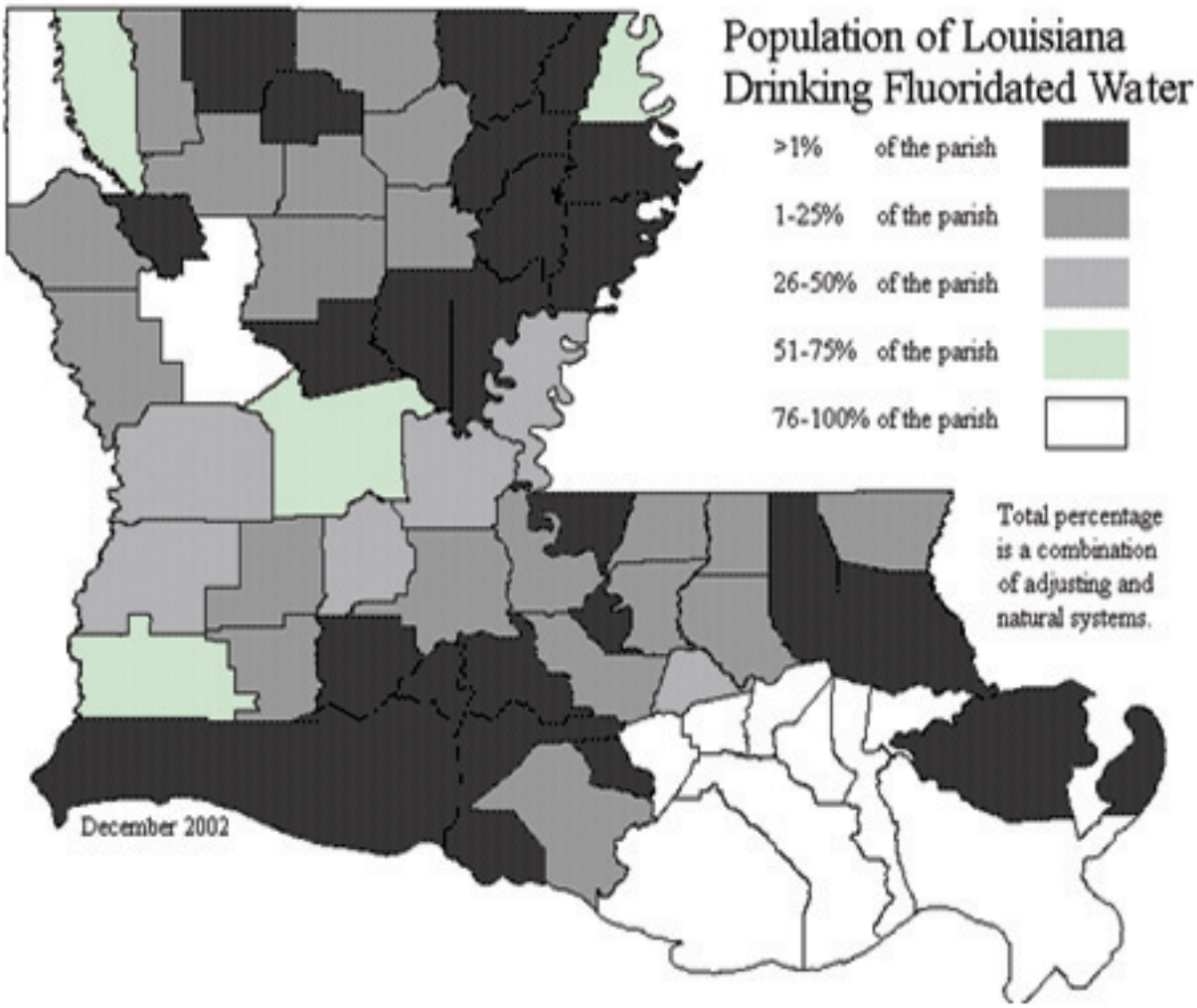
Every dollar spent on community water fluoridation returns a savings of $7 to $42 in treatment costs.[51] The overwhelming weight of scientific evidence indicates the safety and effectiveness of water fluoridation and this has been well documented for over 50 years. Public opinion polls show an overwhelming majority of Americans support water fluoridation.[52]. Studies have found that the median decrease in tooth decay rates before and after community water fluoridation among children aged 4 - 17 years was 29.1%. In studies that measured only decay rates after water fluoridation, the median decrease in tooth decay was 50%. Community water fluoridation was found to help decrease decay rates both in communities with varying decay rates and among children of varying socioeconomic status.[53]. Dental decay can be expected to increase if water fluoridation in a community is discontinued for one year or more, even with the use of topical fluoride products such as fluoridated toothpaste and fluoride rinses. The weighted average cost for community water fluoridation is $0.51 per capita per year in the United States.[54]. Over a life- time, this is the approximate cost of one dental filling, making fluoridation very cost effective.

In Louisiana, approximately 48% of the community water systems are currently fluoridated.[55] The number of water systems in Louisiana that adjust fluoride content decreased from 73 in 1986 to 45 in 1998, and the percentage of the state's population receiving optimally fluoridated water decreased form 54% in 1986 to 49% in 1998. The national Healthy People 2010 Objective is for 75% of the population to receive optimally fluoridated water.[56] Louisiana is well below this goal.

A study of Louisiana Medicaid data by the Centers for Disease Control published in 1999 showed that the average treatment costs for Louisiana Medicaid eligible children in non-fluoridated areas were twice as high as the average treatment costs for Medicaid eligible children in fluoridated areas. The

Medicaid eligible children in non-fluoridated areas were three times more likely to receive dental treatment in a hospital operating room.[57] Community water fluoridation is a cost-effective preventive measure that substantially reduces well documented socioeconomic and racial disparities in the population served by the public water system.

Communities in Louisiana that have Optimally Fluoridated Community Water Supplies



Recommendation:

Increase the percentage of Louisiana residents that receive the benefits of community water fluoridation.

Strategies for Implementation:

- Provide adequate capacity and infrastructure within the Louisiana Department of Health and Hospitals, Office of Public Health, and Environmental Health Services to support community water fluoridation continuation and new community fluoridation start-ups.
- Strengthen collaboration with the Louisiana Dental Association and the Louisiana Dental Hygienists' Association to ensure their members' support in fluoridation efforts throughout the state.
- Strengthen collaboration with advocacy groups interested in oral health to promote community water fluoridation throughout the state.
- Increase the public's awareness of the benefits of community water fluoridation through a statewide media campaign.
- Provide funding incentives for new community water fluoridation programs.

Dental Sealants

Over 80% of dental decay in school-age children occurs on the chewing surfaces of molar teeth.[58]. A dental sealant is a plastic coating that fills the pits and grooves on the chewing surfaces of molar teeth. The plastic material acts as a barrier and prevents plaque, food debris and bacteria from lodging in these areas. It literally seals the tooth surface at the most venerable site and protects it from the organisms that cause dental decay.

According to the National Center for Education in Maternal and Child Health only 18.5% of children and adolescents have at least one sealed permanent tooth (fewer than 1 in 4) and well below the national Healthy People 2010 target of 50%.[59]. The Centers for Disease Control found that school-based dental sealant programs increased the prevalence of dental sealants and reduced or eliminated racial and income disparities among the children receiving dental sealants.[60] The CDC systemic review of sealant programs versus no sealant program where children were examined for dental decay 2-5 years later, found that the median decrease in caries on the chewing surfaces for children 6-17 years of age with sealants was 60%.[61]

In 1998, the Louisiana Office of Public Health conducted an oral screening and found the prevalence rate of dental sealants for Louisiana 3rd grade children to be 22.1%. A study of Louisiana Medicaid claims data between the years 1994-1996 showed a prevalence rate of dental sealants for children aged 6-12 to be 30%. The Healthy People 2010 Objective is for 50% of all children to have at least one sealant on their permanent molar teeth.

Recommendation:

Increase the percentage of school-aged children with dental sealants on their permanent molar teeth.

Strategies for Implementation:

- Increase public awareness of the benefit of dental sealant application to prevent dental caries through a statewide media campaign.
- Identify funding opportunities to increase the number of school children served by school-based dental sealant programs.
- Implement a pilot school-based- dental sealant program in Louisiana schools. Ensure that some selected schools are in designated Health Professional Shortage Area (HPSA) sites.

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FOCUS AREA: LOW PROVIDER PARTICIPATION IN MEDICAID/LaCHIP

Medicaid is the primary vehicle in the United States for making dental care more accessible to low-income children and families. Medicaid provides over 25 million low-income children with comprehensive health insurance, including dental coverage. This includes 1 in 5 children in the United States.[62]

In Louisiana, there are 442,781 children enrolled in Medicaid and 52,753 children enrolled in LaCHIP (a program that extends Medicaid benefits to children whose family incomes range from 100%-200% of the federal poverty guidelines.[63] A study of Louisiana Medicaid claims forms (1998-1999) showed that the total number of 6-9 year old Medicaid eligible children was 98,776. Though all of these eligible children were entitled to dental services, only 37.5% (37,091) received any dental services from Medicaid.[64]

Medicaid eligible children in Louisiana are 3-5 times more likely to have untreated dental decay than non-eligible children. [65] Though there are several factors that contribute to low utilization rates of dental services among low-income families, the most prevalent is finding a dentist to treat them.[66] In some areas of Louisiana, the waiting list to see a dentist that accepts Medicaid is 4-6 months. Waiting lists for dental clinics in New Orleans vary from two months to one year.[67]

A study was conducted to determine the factors that are associated with Louisiana dentists' participation in the Medicaid program. Low reimbursement

rates (61%), broken appointments (80%), and complicated paperwork (42%) were among the most prevalent problems cited.[68]

Reimbursement Rates

"Charity is not a system of care." - Dr. Greg Chadwick, President of the American Dental Association.

Federal Medicaid regulations require that states set reimbursement rates at a level sufficient to enlist enough providers so that dental care "is available to recipients to the same extent those services are available to the general public." In Louisiana, we know that this is not the case. As we enter the 2003 legislative session, reimbursement rates are near 50% of the usual and customary rate (UCR). The American Dental Association has estimated the average cost of operating a dental practice (overhead) to be 64.3% of total revenues. Therefore, a reimbursement rates at or below 60% will not cover expenses for delivering dental services. The last across the board increase to dental Medicaid rates was implemented in 1990.[69]

In 1997, dentists graduating from a four-year program owed, on average, $81,688.[70] This debt often limits dentists' willingness and ability to accept lower paying positions in public health, or accept appreciable numbers of Medicaid clients in private practice. This falls in line with findings from health care researchers. The most common complaint by dentists against Medicaid has been documented as program fees that are well below dentists' usual and customary fees.[71]

Five and three tenths percent (5.3%) of the national health care dollar is spent on dentistry, while less than one percent of Louisiana's Medicaid budget is spent on dentistry.[72] Yet, the Medicaid population typically has greater dental needs than the general population.

States that provide Medicaid dental reimbursement rates that are comparable with market rates have found improvements in access.[73] Louisiana must provide reimbursement rates that are high enough to attract and keep dentists engaged in the Medicaid program.

Recommendation:

Raise Medicaid dental reimbursement rates to the 70th percentile of the ADA fee survey or similar schedule.

Strategies for Implementation:

- Enact legislation that raises Medicaid reimbursement rates to the 70th percentile.
- Monitor reimbursement rates for dental services in order to keep the Medicaid reimbursement rate comparable to the market rate.

Recommendation:

Expand Medicaid EPSDT dental periodicity schedule to include two exams and cleanings per year.

Strategy for Implementation:

- Change Medicaid policy to increase the Louisiana EPSDT periodicity schedule from one yearly exam and cleaning to two yearly exams and cleanings.

Broken Appointments

The American Dental Association reports that 30% of Medicaid patients typically fail to keep their appointments.[74] These high rates of missed appointments by Medicaid recipients have undermined the support of Louisiana dental providers. While Medicaid prohibits charging for missed appointments to cover operating costs, dentists can bill private practice patients when they fail to attend a scheduled appointment.[75] This provides a financial disincentive for dentists to participate in the Louisiana Medicaid program.

There are several factors that contribute to families missing dental appointments. According to information obtained from focus groups conducted by Agenda for Children in2002 and held in the New Orleans area, lack of transportation, changing/inflexible work schedules, and fear of dental visits were the top three reasons for breaking dental appointments. Overall, there was a lack of awareness about the importance of dental visits for preventive oral health practice.

Recommendation:

Educate families on the importance of keeping dental appointments.

Strategy for Implementation:

- Conduct a public awareness campaign that will educate parents on preventive care and the importance of regular dental visits.

Recommendation:

Educate dental providers on Medicaid case management techniques.

Strategies for Implementation:

- Create a continuing education course for dental providers that emphasizes techniques for continuing contact with patient families.

Administrative Burden

In 1998, the American Dental Association (ADA) held a conference where dentists were afforded the opportunity to discuss barriers they identified when working with their state Medicaid programs. Complicated claims handling processes, burdensome preauthorization requirements, slow claims processing, and late payments to providers were among the issues they faced. In addition, many cited burdensome and non-uniform provider enrollment practices.[76]

The Louisiana Dental Association found in a 1997 survey that unreasonable denial of payments, slow payments and complicated paperwork were three of the six most commonly cited problems with the Medicaid program. The administrative burden associated with becoming a Medicaid dental provider appears to ignore the value of dentist's time and services.

Recommendation: Streamline the submittal of claims and reimbursements.

Strategies for Implementation:

- Support electronic claims processing statewide.
- Explore options for financial support for dentists to implement electronic claims processing.
- Reduce prior-authorization requirements.
- Develop a claims corrections process.

Recommendation: Streamline the dental provider contract process.

Strategies for Implementation:

- Clarify program guidelines for dentists and update the program manual regularly with dentist input.
- Create a dentist advisory board that will continue working on policies that reduce administrative burdens.

EPSDT Compliance

"I did not see Medicaid deliver on its legal promise of comprehensive dental care for children through EPSDT. Rather, what I saw in my home town in what is true in nearly every home town across the nation – few dentists, more disease and less dental care for children with treatment needs." – Dr. Burton Edelstein, DDS, MPH

Medicaid-eligible children must receive Early and Periodic, Diagnostic, Screening and Treatment (EPSDT) services according to the federal Omnibus Budget Reconciliation Act of 1989. In addition, 1905(r)(5) of the Social Security Act requires that any medically necessary health care services listed at section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. This legislation was based on an understanding that the optimal health of children can best be achieved by providing access to comprehensive health care benefits

EPSDT benefits require states to provide all Medicaid-eligible children under 21 with comprehensive dental services furnished according to state-defined periodicity schedules. The Health Care Financing Administration explained the EPSDT program as having two major components (2000):[77]

1. Assuring the availability and accessibility of required health care resources. (This includes an annual dental screen, plus diagnostic, preventive and treatment services for all eligible children.)
2. Helping Medicaid recipients and their families effectively use these resources.

One out of every four children, and one in three infants, are currently covered under Medicaid and are entitled to comprehensive benefits through the EPSDT program.[78] In spite of mandated dental coverage for eligible children, only 20% of Medicaid eligible children in the U.S. are receiving any type of dental services.[79] According to the federal Department of Health and Human Services, in 2000, 19% of Medicaid and CHIP beneficiaries received preventive dental services.[80] In 1999, Louisiana Medicaid reported to have 26.8% of Medicaid and LaCHIP beneficiaries receiving any dental service.

In many cases, compliance with EPSDT requirements could be underreported. According to current federal guidelines, it is very difficult to accurately measure EPSDT compliance. Even the U.S. Surgeon General suggested states "overhaul EPSDT dental programs." [81] Because of the great potential of this comprehensive legislation, it is criminal (literally) not to ensure compliance.

Recommendation:

Increase research efforts to assess EPSDT compliance.

Strategy for Implementation:

- Revise the Louisiana Medicaid0EPSDT data collection to accurately identify the number of children who receive all of their EPSDT screens in a timely fashion, with zero impact on the administrative responsibilities of dental providers.

FOCUS AREA: AVAILABILITY OF DENTISTS

In the next quarter-century, the general population is expected to increase dramatically, while the number of practicing dentists in the U.S. is expected to decline. This will result in the lowest ratios of dentists to population that has been recorded throughout the 20th century.[82] However, this shortage of dentists will not affect all populations equally. Higher income areas have two-thirds more dentists per capita than low-income areas, and the supply of dentists per capita decreased in low and medium income areas during the 1980s while it increased in higher income areas.[83]

Rural Louisiana

"Of the 200 persistently poor counties in America (those with a 20% poverty rate or higher) 195 are rural." – Save the Children, 2002

In the U.S., there are 2.5 million rural children living in poverty. It is a well-documented fact that children living in rural areas do not receive adequate preventive health care. Children living in rural areas do not receive the same level of preventive health care have greater long-term health problems and less access

to health care than their urban counterparts. Rural children are 50% more likely not to have health insurance than urban children, and 68% of all federally designated "health professional shortage areas" (HPSA) are in rural America.[84]

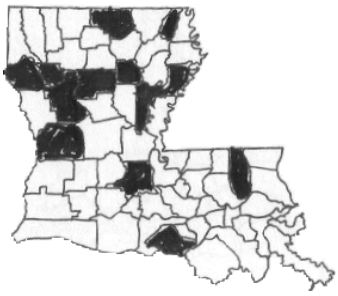
Reasons behind rural poverty are quite different from those behind urban poverty. Rural communities often lack the people, money, and skills necessary to support community resources that are necessary for the development of healthy children, including health clinics, public transportation and schools.[85] For similar reasons, barriers to accessing dental services are also different for children in rural areas compared to children in urban areas. Transportation, shortage of dentists, and shortage of preventive and health promotion programs top the list of reasons children lack adequate oral health care.[86]

Transportation is one of the largest barriers to accessing dental services in rural areas. The Children's Health Fund conducted a survey of families in 2001. This survey found that approximately 20% of poor children lack access to health care because they have no transportation, and 75% of those children live in rural areas with no public transportation. Thirty-one percent (31%) of families surveyed lived more than 10 miles from the nearest health facility, and more than 7% lived between 25 and 50 miles from the nearest doctor's office, health clinic, or hospital. The majority of rural families do not own vehicles, and at least 40% of rural areas are not serviced by public transportation.[87]

Even when children are able to access transportation, there is no guarantee they will be able to find a dentist. There are approximately 2000 dentists practicing in Louisiana.[88] Though this number may initially appear adequate, Oral Health America, in their 2001 national report card, gave Louisiana a grade of D in availability of dentists.[89] In 2002, 20.3% (13) of Louisiana's parishes were designated as a whole county Dental HPSA, and 4.7% (3) of Louisiana's parishes were designated as a partial county Dental HPSA [90]. Tensas parish had no practicing dentists. Louisiana ranked 38th in dentists per capita, with 39.5 dentists per 100,000 residents. This is well below the national average of 48.4 dentists per 100,000 residents.

A Dental HPSA is defined as a geographic area that is a rational area for the delivery of dental services, that has a population to full-time-equivalent dentist ratio between 4000:1 and 5000:1, and in which dentists in contiguous areas are inaccessible.

Louisiana's 13 Whole Parish Shortage Areas



Cardwell	Tangipahoa
Catahoula	Tensas
Desoto	Union
Natchitoches	Vernon
Red River	West Carroll
St. Landry	Winn
St. Mary	

The prevailing notion that there are limited opportunities for dental practice in rural areas is inaccurate.[91] There is a high demand for dental professionals as well as accessible dental health clinics and preventive programs.

Recommendation:

Increase the ratio of dentists to residents in designated dental HPSA's in Louisiana.

Strategies for Implementation:

- Create a state supported loan repayment program that will provide financial incentives for dentists to work in rural areas in federally designated dental HPSA's.
- Develop relationships between DHH and community development corporations in rural parishes that can provide financial aid with start up costs for dental offices in designated dental HPSA's.
- Expand the state income-tax credit for dental providers in dental health professional shortage areas (HPSAs) to include dentists already serving the community.

Recommendation:

Encourage interested dentists to apply for federal loan repayment program.

Strategy for Implementation:

- Provide educational outreach to dental students about the federal loan repayment program through LSU School of Dentistry.

Recommendation:

Relieve families of financial burden of accessing transportation to dental appointments.

Strategy for Implementation:

- Expand Medicaid to cover transportation for families living in parishes that are federally designated dental HPSA's.

Pediatric Dentists

It is not until Age 7 that 90% of children visit a dentist. It is age 10 for African American children, age 11 for uninsured children, and age 16 for Hispanic children. – Diann Bomkamp

"I find when children see a Dental Provider and the Provider presents to me that he does not have patience for children that age, I change providers (after parent contact) to one who will make the kids at ease and explain to them what he will be doing to alleviate fear of the unknown." – Lethia G. Wimms, Avoyelles Head Start – Central Office Health Specialist.

The U.S. Census Bureau projects that within the next 25 years, the number of children under age 15 will increase by 8 million. This increase coincides with an acute shortage of pediatric dentists. According to M. Davis, a pediatric dentist, a shortage of dentists specializing in the care of children will have the greatest effect on children with limited economic resources and those with complex oral health problems.[92]

In Louisiana, there are only 15 pediatric dentists that are accepting an appreciable number of Medicaid patients.[93]. Of all Medicaid children who were seen for dental care, approximately 40% were seen in pediatric dental offices.[94] Of children ages 2-5 years of age that fall below 100% of poverty, most are treated by pediatric dentists. In addition, over half of the medically complex children receiving oral health care in the United States were seen by pediatric dentists. According to the American Association of Pediatric Dentistry, children with more advanced oral disease are more likely to require the services of a specialist in Pediatric Dentistry.[95]

The shortage of pediatric dentists is due in large part to the inadequate number of training positions for the specialty. There were 200 training positions in

the U.S. in 1980 and there are only 160 in 2002 [96] The applicant pool is highly qualified and sufficient in size; however there is not enough funding to support additional training positions in America's schools of dentistry.

Additionally, the shortage of pediatric dentists is a response to the dental school faculty vacancies in Pediatric Dentistry. In 1997, there were at least 16 vacancies in the 54 national dental schools.

Even the Surgeon General, in his 2000 report on Oral Health in America suggests that the number of pediatric dentists be expanded in order to ensure an adequate oral health workforce. General dentists are often unwilling or unprepared to see very young children. This problem only becomes worse when placed in the context of a pediatric dental shortage. Therefore, in addition to increasing the number of pediatric dentists, there must be an increase in general dentists treating young children and non-dental providers must be trained to provide referrals, preventive care, and oral health guidance to families with young children.

Recommendation:

Increase the number of training positions for pediatric dentists at LSU School of Dentistry.

Strategy for Implementation:

- Access available resources for residencies in pediatric dentistry.
- Identify new funding opportunities for residencies in pediatric dentistry.

Recommendation:

Increase the number of general dentists willing to treat young children.

Strategies for Implementation:

- LSU School of Dentistry should ensure that the curriculum provides adequate experience to dental students on techniques needed in order to treat young children.
- LSU School of Dentistry should encourage students training to become general dentists to accept young children as patients when they enter private practice.

Recommendation:

Train non-dental providers to provide referrals, oral hygiene practices, and parental oral health guidance/counseling to families with young children.

Strategies for Implementation:

- Develop curriculum and information packets that can be used to train non-dental health care providers on oral health preventive practice.
- Train pediatric nurses, pediatricians, and medical students, through medical school and continuing education courses, to provide referrals, increase oral health awareness, and provide fluoride supplements in non-fluoridated are
- Monitor North Carolina's fluoride varnish program for its success or failure to reduce early childhood caries in high- risk populations.
- Investigate the possibility of implementing a pilot program similar to North Carolina's fluoride varnish program.

Recommendation:

Utilize the early childhood educators to promote oral health for the children in childcare facilities.

Strategies for Implementation:

- Provide education and training on oral health to childcare providers.

School Based Health Centers (SBHC)

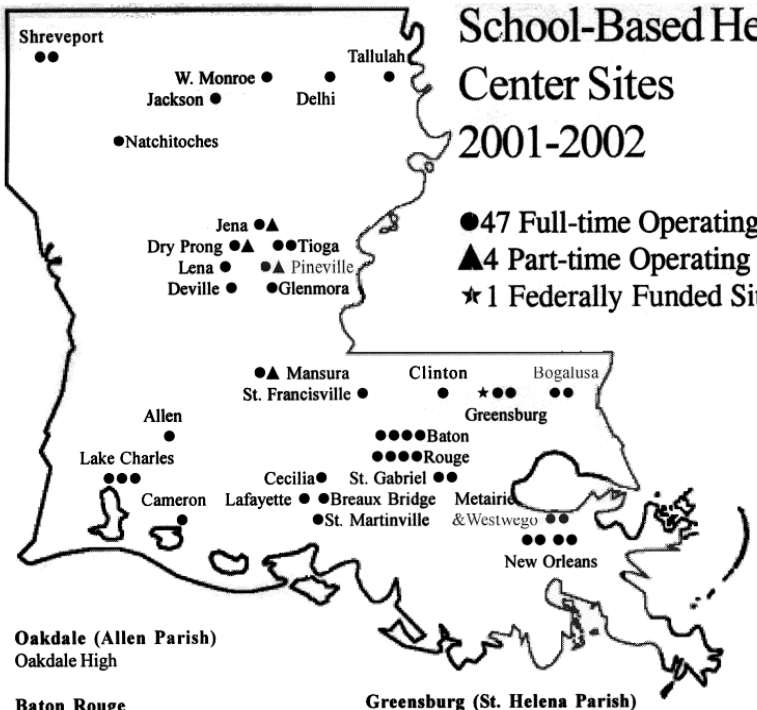
"One proven strategy for reaching children at high-risk for dental disease is providing oral and dental health services in school-based health centers." Grant Markers in Health Issue Dialogue. 2001, May. Filling the Gap: Strategies for Improving Oral Health.

In 1991, the Adolescent School Health Initiative Act authorized the Office of Public Health to establish school-based health centers in public schools throughout the state. The four basic assumptions of Comprehensive School Health are:

1. The primary goal of schools is education.
2. Education and health are linked. Educational outcomes are related to health status, and health outcomes are related to education.
3. There are basic health needs of children and young people. These include: nurturing and support; timely and relevant health information; knowledge and skills necessary to adopt healthful behavior: and access to health care.

4. The school has the potential to be a crucial part of the system that provides basic health needs. By the end of the 2001-2002 school year, there were 53 school-based health centers throughout Louisiana providing care to 50,000 Louisiana children in 23 parishes. But only 3.4% of all students attending public schools in Louisiana receive services from school based health school-based health centers.

Louisiana Adolescent School Health Initiative



Oakdale (Allen Parish)
Oakdale High

Baton Rouge
(E. Baton Rouge Parish)
Capitol High
Glen Oaks High
Glen Oaks Middle
Istrouma High
Northeast Elementary
Northeast High
Prescott Middle
Westdale Middle

Bogalusa (Washington Parish)
Bogalusa High
Bogalusa Jr. High

Clinton (E. Feliciana Parish)
Clinton Middle

Creole (Cameron Parish)
South Cameron High

Delhi (Richland Parish)
Delhi Jr. & Sr. High

Deville (Rapides Parish)
Buckeye High

Dry Prong (Grant Parish)
Dry Prong Jr. High
Pollock Elementary

Glenmora (Rapides Parish)
Glenmora Elementary & High

Greensburg (St. Helena Parish)
St. Helena Central Elementary
St. Helena Central Middle
St. Helena Central High (Federal Funding)

Jonesboro (Jackson Parish)
Jonesboro Jr. &Sr. High

Jena (LaSalle Parish)
Jena Jr. High
Jena Sr. High

Metairie & Westwego
(Jefferson Parish)
Bunche Middle
Butler Elementary

Lafayette (Lafayette Parish)
Northside High

Lake Charles (Calcasieu Parish)
Clifton Elementary
Molo Middle
Washington-Marion High
(also serving Combre/Fondel & Wilson)

Lena (Rapides Parish)
Northwood PreK-12

Mansura (Avoyelles Parish)
Mansura Middle
Avoyelles Charter

Campti (Natchitoches Parish)
Lakeview Jr. & Sr. High

New Orleans (Orleans Parish)
Marion Abramson High
George W. Carver Sr. High
John McDonogh Sr. High
Booker T. Washington High

Pineville (Rapides Parish)
Pineville Jr. High
Slocum Elementary
Tioga Jr. High
Tioga Sr. High

St. Francisville (W. Feliciana Parish)
Family Service Center

St. Gabriel (Iberville Parish)
East Iberville Elementary & High
Iberville Elementary

St. Martin Parish
Breaux Bridge Schools
Cecilia Schools
St. Martinville Schools

Shreveport (Caddo Parish)
Atkins Elementary
Linwood Middle

Tallulah (Madison Parish)
McCall Jr. & Sr. High

W. Monroe (Ouachita Parish)
Riser Middle

There were 2,956 dental visits made to Louisiana school-based health centers in 2000-2001. School-based health centers improve children's access to health care by avoiding financial and other barriers in the existing health delivery system. Children in or linked to school settings have easy access to services and thus much more likely to get the care that they need. School-based health centers, in partnership with community dental providers, eliminate barriers to dental care. In rural school-based health centers from 2000-20001, dental and oral was listed as one of the top ten reasons for visiting the school-based health center.

Recommendation:

Increase the number of school-based health centers with an oral health component.

Strategies for Implementation:

- Identify funding opportunities to expand the dental treatment component of school-based health centers.
- Identify dental providers in the communities who will treat referrals from school-based health centers without a dental clinic.
- Provide oral health training for non-dental health professionals in school-based health centers without a dental component.

Dental Auxiliary Workforce

Under circumstances in which access to dental care is extremely limited, employing expanded function dental assistants and dental hygienists to provide a limited number of services traditionally restricted to dentists by state practice acts is one way to increase the efficiency of the nation's dental care delivery system.[97] Oral habits must be established early, and utilizing expanded dental personnel to reach children in schools, childcare settings, or other public settings provides an economical and effective way to reach more children in underserved areas. With proper diagnosis by a licensed dentist, the initiation of fluoride rinse and varnish programs in the school setting may be a consideration. Schools provide a captive audience and can ensure that the children participate when parental consent has been obtained.

Recommendation:

Increase the utilization of dental hygienists and expanded duty dental assistants in the community work force setting within underserved areas of the state.

Strategies for Implementation:

- Investigate expanding general supervision for dental hygienists working in schools, childcare centers, hospitals, community health centers, and other public settings within underserved areas, in conjunction with the Louisiana Dental Association, and the Louisiana Dental Hygienists' Association, and with the approval of the Louisiana State Board of Dentistry.
- Investigate expanding the duties of expanded duty dental assistants working in schools, childcare centers, hospitals, community health centers and other public setting within underserved areas, in conjunction with the Louisiana Dental Association, and the Louisiana Dental Assistants' Association, and with the approval of the Louisiana State Board of Dentistry.

FOCUS AREA: COMMUNITY EDUCATION

Public Awareness

"Education and health are linked. Educational outcomes are related to health status, and health outcomes are related to education".[98] Children who take a test while they have a toothache are unlikely to score as well as children who are not distracted by pain.[99] Poor oral health causes American children to lose 51 million school days each year. Children living in poverty suffer nearly 12 times more restricted-activity days than do children from higher-income levels.[100] Poor dental health leads to pain, infection, dysfunction and poor performance.[101] These conditions can adversely affect learning, communication, nutrition and other activities necessary for normal growth and development.[102] Health behaviors that assure good oral health must be established in early childhood. Former Surgeon General C. Everett Koop stated: "You are not healthy without good oral health." Personal responsibility for good oral health must be emphasized. Fear and misunderstandings about oral health must be eliminated. The benefits of preventive oral health strategies including dental sealants and community water fluoridation must be promoted throughout the state.

In a national study conducted among 1000 respondents including mothers and/or primary caretakers of children up to the age of 12, the findings show that

many have concerns about their child's oral health and do not feel that they have enough information about oral health measures. Gaps in information and awareness levels exist about fluoride benefits and limitations, gum disease, flossing, dentist visits and appropriate age to start specific health care behaviors.[103] Parents report that dental care is the greatest unmet health care need of their children, and also a leading health care "want".[104] Three times as many parents report that their child has an unmet need for dental care as for medical care according to an analysis by the National Health Interview Survey Data.[105] Twenty-five percent (25%) of children living in poverty have not seen a dentist before entering kindergarten.[106]

Recommendation:

Increase public awareness through a statewide media campaign about the importance of oral health and the impact of poor oral health on the systemic health of each individual.

Strategies for Implementation:

- Develop a comprehensive statewide oral health education and awareness campaign.
- Insure that the messages are targeted to populations at greatest risk and that the messages are culturally appropriate.

Recommendation:

Implement comprehensive school health curricula with an oral health education and prevention component in all Louisiana schools.

Strategies for Implementation:

- Design a comprehensive oral health education curriculum for elementary and secondary school children.
- Coordinate with school health educators and school- based health centers to assure that oral health issues are addressed within the framework of comprehensive school health.
- Work with the Department of Education and state legislators to promote oral health as a mandated part of the school health curriculum.

Pre-term Births:

Pre-term birth, and the accompanying increased likelihood of morbidity and mortality, is the leading perinatal problem in the United States. Despite widespread use of drugs to arrest pre-term labor, there has been no significant decrease in low birth weight or pre-term infants in the last 20 years. Evidence from many sources has supported the hypothesis that sub-clinical infection is a significant cause of pre-term birth. Evidence also supports the association between periodontal infections in the pregnant mother and pre-term low birth weight babies. Microbes or microbial toxins can enter the uterine cavity during pregnancy by the blood-borne route from a non-genital focus. It is this route that the association between periodontal infections and pre-term low birth weight infants has been established. Dr. Jeffcoat from the University of Alabama has established that the bacteria associated with oral disease are similar, if not identical with, the bacteria associated with upper genital tract infections. Chronic oral infection has been associated with adverse pregnancy outcomes.[107]

In 1999, Louisiana ranked 49th among the states in the percent of low birth weight babies born to mothers living here. Only Mississippi and the District of Columbia had worse statistics. In that same year, Louisiana ranked 47th in the nation in infant mortality rates, with 9.2 deaths for every 1000 live births. Louisiana's teen birth rate (age 15-17) for this time period was 38 births per 1,000 with only five states scoring worse. Louisiana consistently scored at the lowest levels for all national health status indicators.[108]

Louisiana PRAMS (Pregnancy Risk Assessment Monitoring System) data from 1999 shows that 26.7% of pregnant women experienced some type of dental problem during their pregnancy.[109] Medicaid eligible pregnant women aged 21 or older are not eligible for dental benefits so many are unable to seek needed dental treatment. Preliminary studies conducted at the University of Alabama by Dr. Majorie Jeffcoat have shown that pregnant women with periodontal disease who are treated with scaling and root planing had significantly fewer pre-term births than the members of the control group who received no dental treatment.

Women in Louisiana who are Medicaid eligible and over the age of 21 presently have access to coverage for "pregnancy related" services throughout the duration of their pregnancy and for three months beyond. By expanding this coverage to include dental benefits, women with periodontal disease can reduce their risk of having a pre-term, low birth weight baby.

Recommendation:

Provide prenatal education to all pregnant women with an emphasis on the relationship between poor maternal periodontal health and pre-term low birth weight babies; and establish good maternal oral health behaviors for the infant.

Strategies for Implementation:

- Reach prenatal women through the WIC program and other community health centers to provide oral health education emphasizing the relationship between poor periodontal health and pre-term low birth weight babies.
- Establish partnerships with all health care providers to advocate oral health as part of good prenatal care.
- Provide information and training on the association of periodontal disease and pre-term low birth weight babies and early childhood caries to health care professionals that have direct contact with the pregnant mother and can provide this information during the pregnancy.
- Provide information to the public about the association between pre-term low birth weight babies and periodontal disease in the mother through the statewide media campaign.

Recommendation:

Provide dental coverage for Medicaid eligible pregnant women beyond the age of 21.

Strategies for Implementation:

- Change Medicaid policy to provide dental coverage to Medicaid eligible pregnant women beyond the age of 21.
- Provide information to state legislators and the state Medicaid office on the cost savings associated with reducing pre-term low weight births for women with periodontal disease.
- Establish partnerships with other pre-natal health care providers to advocate good maternal oral health as an important factor in producing a healthy baby.

Baby Bottle Caries

Early childhood tooth decay, "baby bottle caries", is an infectious disease caused by the bacteria mutans streptococci. Children with early childhood caries are infected with high levels of this bacteria which is generally acquired from the child's mother. Early childhood tooth decay affects approximately 5% to 10% of infants and young children in the United States.[110] The American Academy of Pediatric Dentistry recommends that children have their first dental exam by 12 months of age. This will help facilitate access to effective preventive services for children at high risk for early childhood caries.

Infant feeding practices in which children are put to bed with bottles of formula or other sweetened drinks have been associated with early childhood caries. Consumption of juice from a bottle should be avoided. Children should be weaned from the bottle at 12-14 months of age. To reduce the risk of caries, childcare providers should limit the exposure time to fermentable carbohydrates by removing the bottle when feeding is complete. Oral hygiene measures for the child should be implemented as soon as the first teeth erupt. The parents or primary caregivers are responsible for cleaning the infant and toddler's teeth.

The Health Care Financing Administration (currently Centers for Medicare and Medicaid Services) has estimated that Medicaid pays $100-$900 million per year for operating room charges associated with baby bottle caries.[111] It has been estimated that treatment for this disease can exceed $1000 per child. It is critical that primary caretakers of young children know the consequences of this improper feeding practice.

Recommendation:

Implement an oral health component developed specifically for the young child that can be utilized in all childcare centers.

Strategies for Implementation:

- Work with Early Head Start/Head Start agencies to ensure that oral health education and good dental health practices are promoted among parents and children.

- Work with childcare centers to ensure that oral health education and good dental health practices are promoted.
- Provide formal training to early childhood educators on preventive oral health practices.
- Involve primary care physicians and pediatricians in the education of parents about early childhood caries.
- Collaborate with child advocacy groups to educate parents and primary caregivers on the consequences of early childhood caries.
- Provide information on early childhood caries to use in a public awareness media campaign.

FOCUS AREA: CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Special Olympics Special Smiles Global Clinical Advisor Dr. Steven Perlman states "All over the world, people are recognizing the importance of oral health to total health, and most importantly, the oral health disparities of individuals with mental retardation."

Low-income and minority children and children with special health care needs are at the greatest risk of inadequate access and poor oral health.[112] The proportion of the U.S. population found to have disabilities has risen in the past 25 years, with the greatest number of children and young adults now reporting disabilities. Most studies indicate dental disease in some "disabled" populations, not necessarily as a direct result of the disabling condition, but due to personal and professional dental neglect.[113] The inability to obtain dental care is the number one health problem that parents and caregivers of individuals with mental retardation face.[114]

A recent study, conducted by a pediatric dental resident at the University of Texas, found that many U.S. dental students are inadequately prepared to provide services for individuals with mental retardation, but when given experience dealing with these patients, a more positive understanding of their capabilities was reached. Challenging behavior is a significant barrier to care for some disabled individuals. Lack of training in sophisticated management techniques and complex medical problems also make dental professionals unwilling to care for this

population.[115] In addition, disabled individuals often have special needs that create additional barriers to obtaining care. For example, some disabled individuals require intravenous sedation or general anesthesia during dental treatment. Treatment for wheelchair bound, blind, or deaf patients also requires special accommodations.[116]

The Americans with Disabilities Act (P.L. 101-336) requires that dentists treat patients with disabilities on the same basis as they treat patients without disabilities. Dentists cite the following barriers to providing care for children and adolescents with special health care needs: limitations of the office, scheduling complications, children's and adolescents' behavior problems, inadequate financial compensation, inadequate numbers of dentists with appropriate training and hospital/surgical privileges, and consent issues.[117]

Data from the 1994-1995 National Health Interview Survey on Disability found that 1 in 12 children with special health care needs was unable to get needed care.[118] One in four parents of a child with special health care needs state that their child is in need of dental care.[119] According to the U. S. Census Bureau (1990), Louisiana had the sixth highest prevalence (29.08%) in the nation of disabilities among children under 18.[120]

Recommendation:

Increase the number of dentists who are willing to treat children with special health care needs.

Strategies for Implementation:

- Provide adequate training in the dental curriculum for treating young patients who are mentally and physically challenged.
- Provide clinical experience in treating these patients to the dental student.
- Provide expansive continuing training and education to practicing dentists in the community for treating young patients with special health care needs.

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